

Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-294

Employees' Manual, Title 8
Medicaid Appendix

January 16, 2009

SCREENING CENTER MANUAL TRANSMITTAL NO. 09-1

ISSUED BY: Bureau of Long-Term Care, Division of Medical Services

SUBJECT: **SCREENING CENTER MANUAL**, Table of Contents, new; Chapter III, *Provider-Specific Policies*, Table of Contents (page 2), revised; pages 3, 4, 13, 14, 15, 23, and 41 through 62, revised; page 63, new; and the following forms:

RC-0080 *Screening Components by Age*, revised
Remittance Advice, revised

Summary

Screening Center Chapter III is updated to:

- ◆ Revise the schedule of screening components by age to conform to current requirements.
- ◆ Remove references to case management. The Centers for Medicare and Medicaid Services published final regulations on targeted case management (CMS 2237) on March 3, 2008. Under these regulations, case management services are designed to address populations with a medical diagnosis, not a preventive care population. Due to this regulation, the services of informing and care coordination will now be provided through an interagency agreement with the Iowa Department of Public health, not as a component of Medicaid screening center services.
- ◆ Add references to health education on dental sealants for deciduous molars and bicuspsids, since Medicaid coverage of sealants has been expanded.
- ◆ Revise standards for vision screenings to incorporate the recommendations in ***Bright Futures***, Third Edition.
- ◆ Revise standards for hearing screening to incorporate the recommendations of the Joint Committee on Infant Hearing.
- ◆ Clarify requirements for patient encounter records.
- ◆ Add codes for home visits.
- ◆ Refer to the Vaccines for Children web site for the current list of covered vaccines.
- ◆ Revise a procedure code definition.
- ◆ End-date two fluoride codes, as fluoride varnish is the only code needed.
- ◆ Update instructions for the *Health Insurance Claim Form*, CMS-1500.
- ◆ Update the *Remittance Advice* sample and instructions.

Date Effective

February 1, 2009

Material Superseded

Remove the following pages from **SCREENING CENTER MANUAL** and destroy them:

<u>Page</u>	<u>Date</u>
Contents (page 2)	June 1, 2007
Chapter III	
RC-0080	6/05
3, 4, 13-15, 23, 41-58	June 1, 2007
RA-1500	Undated
59-62	June 1, 2007

Additional Information

The updated provider manual containing the revised pages will be available by February 1 at: **www.ime.state.ia.us/providers**

Until then, this letter and the revised pages will be available at:

<http://www.dhs.iowa.gov/policyanalysis/PolicyManualPages/medprovg1.htm>

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

Iowa Medicaid Enterprise
Provider Services
PO Box 36450
Des Moines, IA 50315

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to Iowa Medicaid Enterprise Provider Services Unit.


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Screening Components by Age

Age	Infancy						Early Childhood						Middle Childhood				Adolescence				
	nb ¹	by 1 m	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	3 yr	4 yr	5 yr	6 yr	8 yr	10 yr	12 yr	14 yr	16 yr	18 yr	20+ yr
HISTORY																					
Initial/Interval	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
PHYSICAL EXAM	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
MEASUREMENTS																					
Height/Weight	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Head Circumference	★	★	★	★	★	★	★	★	★	★	★	★									
Weight for Length	★	★	★	★	★	★	★	★	★												
Body Mass Index										★	★	★	★	★	★	★	★	★	★	★	★
Blood Pressure	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	★	★	★	★	★	★	★	★	★	★	★
NUTRITION																					
ASSESS/EDUCATION	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
ORAL HEALTH ²																					
Oral Health Assessment	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dental Referral							★		★	Every six months											
SENSORY SCREENING																					
Vision	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	O	O	O	O	O	O	O	O	RA	O	O
Hearing	O	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	O	O	O	O	O	RA	RA	RA	O	RA
DEVELOPMENTAL/ BEHAVIORAL ASSESSMENT ³																					
Developmental Screening						★			★		★										
Autism Screening									★	★											
Developmental Surveillance	★	★	★	★	★		★	★		★	★	★	★	★	★	★	★	★	★	★	★
Psychosocial/Behav. Assess.	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Alcohol and Drug Use Assess.																	RA	RA	RA	RA	RA
PROCEDURES																					
Hgb/Hct		★																★			
Urinalysis													★					★			
Metabolic screening ⁵																					
Lead Screening						RA	RA		★ or RA	RA	★ or RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
Tuberculin Test		RA			RA		RA		RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
Dyslipidemia Screening											RA	RA		RA	RA	RA	RA	RA	RA	★	RA
STI Screening																	RA	RA	RA	RA	RA
Cervical Dysplasia Screening-																	RA	RA	RA	RA	RA

KEY: ★ To be performed

○ Objective, by a standard testing method

★ Perform test once during indicated time period

RA Risk assessment to be performed, with appropriate action to follow if positive

Continued on next page.

HEMOGLOBINOPATHY	Only once (newborn screen) and offered to adolescents at risk.
TUBERCULIN TEST	Tuberculosis testing per recommendations of the Committee on Infectious Diseases, published in the current edition of <i>Red Book: Report of the Committee on Infectious Diseases</i> . Testing should be done on recognition of high-risk factors.
LEAD	Starting at 12 months, assess risk for high dose exposure.
GYNECOLOGIC TESTING	Pap smear for females who are sexually active or (if the sexual history is thought to be unreliable) age 18 or older. Pregnancy testing should be done when indicated by the history.
STI	All sexually active patients should be screened for sexually transmitted infections (STIs)
ANTICIPATORY GUIDANCE	Refer to the specific guidance by age as listed in Bright Futures Guidelines. (Hagan JF, Shaw JS, Duncan PM, eds. <i>Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents</i> . 3 rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008)

- ¹ Every infant should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital, to include evaluation for feeding and jaundice. Breastfeeding infants should receive formal breastfeeding evaluation, encouragement, and instruction as recommended in AAP statement “Breastfeeding and the Use of Human Milk” (2005) [URL: <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;115/2/496>]. For newborns discharged in less than 48 hours after delivery, the infant must be examined within 48 hours of discharge per AAP statement “Hospital Stay for Healthy Term Newborns” (2004) [URL: <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;113/5/1434>].
- ² The oral health assessment should include dental history, recent problems, pain, or injury and visual inspection of the oral cavity. Referral to a dentist should be at 12 months, 24 months, and then every 6 months, unless more frequent dental visits are recommended.
- ³ At each visit, age-appropriate physical examination is essential, with infant totally unclothed, older child undressed and suitably draped.
- ⁴ An immunization review should be performed at each screening, with immunizations being administered at appropriate ages, or as needed.
- ⁵ The Iowa Newborn Screening program tests every baby born in Iowa for the following disorders: hypothyroidism, galactosemia, phenylketonuria, hemoglobinopathies, congenital adrenal hyperplasia, medium chain acyl Co-A dehydrogenase (MCAD) deficiency, biotinidase deficiency, hearing, cystic fibrosis, and any other amino acid, organic acid, and fatty oxidation disorders detectable by tandem mass spectrometry.



- ◆ **Developmental disability.** Examples include increased risk of altered energy and nutrient needs, oral-motor or behavioral feeding difficulties, medication-nutrient interaction, and tube feedings.
- ◆ **Psychosocial factors.** Examples include behaviors suggesting an eating disorder. Children with an eating disorder should also be referred to community resources and to their primary care provider for evaluation and treatment.

This is not an all-inclusive list. Other diagnoses may be appropriate and warrant referral to a licensed dietitian.


Families that are eligible for nutritional counseling through the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) must provide a statement that the need for nutritional counseling exceeds the services available through WIC. Maintain a copy of the statement in the child's record.

3. Care Coordination

This service is reimbursed by the Iowa Department of Public Health through a contract with the Department of Human Services.

NOTE: CMS policy states, "payments for allowable Medicaid services must not duplicate payments that have been, or should have been, included as part of a **direct** medical service.... Activities that are considered integral to, or an extension of, the specified covered service are included in the rate set for the direct service, therefore they should not be claimed as another service. For example, when an agency provides a medical service, the practitioner should not bill separately for the cost of a referral. These activities are properly paid for as part of the medical service."

If the family needs a service that is not covered by Medicaid, make a good-faith effort to locate providers who will furnish those services.

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4. Transportation

To help ensure that members have access to medical care, the Department provides reimbursement for transportation to necessary medical care, dental care, and mental health care.

- ◆ **Local transportation:** Under the EPSDT "Care for Kids" program, local (in town) transportation is available for screening, diagnosis, and treatment. The transportation service is covered through agencies designated by the Department of Public Health. Screening centers are responsible for linking families with local transportation resources.
- ◆ **Out-of-town transportation:** Families seeking medical care for their children outside their own community should contact the local Department of Human Services caseworker to reimburse out-of-town transportation.

Payment is limited to situations when it is necessary for the member to travel outside the community to receive needed medical care, or when the member lives in a rural area, to travel to the nearest community to receive care.



Suggested Health Education Topics: 2 - 5 Years

Oral Health

Appropriate use of bottle and breast feeding	Teething and tooth eruption
Fluoride exposure: toothpaste, water, topical fluoride and supplements	Regular dental visits
Oral care: parental tooth brushing and flossing when the teeth touch	Feeding and snacking habits: exposure to carbohydrates and sugars
Gingivitis and tooth decay	Use of sippy cup
Non-nutritive sucking (thumb, finger and pacifier)	Dental injury prevention
	Sealants on deciduous molars and permanent six-year molars

Injury Prevention

CPR training	Purchase of bicycles
Booster car seat	Put up warning signs
Burns and fire	Restricted play areas
Farm hazards: manure pits, livestock, corn cribs, grain auger, and grain bins	Street danger
Dangers of accessible chemicals	Teach child how to get help
Importance of protective helmets	Toys
Machinery safety	Tricycles
No extra riders on tractor	Walking to school
Play equipment	Water safety
	Gun storage

Mental Health

Adjustment to increasing activity of child	Child care
Balancing home, work, and school	Sibling rivalry
Helping children feel competent	Managing emotions

Nutrition

Appropriate growth pattern	Managing meal-time behavior
Appropriate intake for age	Physical activity
Control issues over food	Snacks

Other Preventive Measures

Adequate sleep	TV watching
Care of illness	Age-appropriate sexuality education
Clothing	School readiness
Common habits	Toilet training
Importance of preventative health visits	Smoke-free environments
Safety rules regarding strangers	
Social skills	



Suggested Health Education Topics: 6 - 12 Years

Oral Health

Fluoride exposure: toothpaste, water, topical fluoride and supplements	Regular dental visits
Oral care: supervised tooth brushing and flossing	Dental referral: orthodontist
Gingivitis and tooth decay	Diet and snacking habits: exposure to carbohydrates, sugars, and pop
Non-nutritive sucking (thumb, finger and pacifier)	Dental injury prevention
Permanent tooth eruption	Sealants on bicuspid and 6- and 12-year molars
	Mouth guards for sports
	Smoking and smokeless tobacco

Injury Prevention

Bicycle (helmet) safety	Emergency telephone numbers
Car safety	Machinery safety
CPR training	Mowing safety
Dangers of ponds and creeks	Self-protection tips
Electric fences	Sports safety
Farm hazards: corn cribs, grain auger, gravity flow wagon, livestock	Street safety
Fire safety	Tractor safety training
Gun and hunter safety	Water safety
	High noise levels

Mental Health

Discipline	Developing self esteem
Emotional, physical, and sexual development	Nurturing friendships
Handling conflict	Peer pressure and adjustment
Positive family problem solving	School-related concerns
	Sibling rivalry

Nutrition

Appropriate intake for age	Inappropriate dietary behavior
Breakfast	Managing meal time behavior
Child involvement with food decisions	Peer influence
Food groups	Physical activity
	Snacks

Other Preventive Measures

Adequate sleep	Safety regarding strangers
Clothing	Age-appropriate sexuality education
Exercise	Social skills
Hygiene	Preparation of girls for menarche
Importance of preventative health visits	Sports
Smoke-free environments	Stress
	TV viewing



Suggested Health Education Topics: Adolescent (13 - 21 Years)

Oral Health

Fluoride exposure: toothpaste, water and topical fluoride
Oral care: tooth brushing and flossing
Gingivitis, periodontal disease and tooth decay
Permanent tooth eruption
Regular dental visits
Dental referral: orthodontist and oral surgeon for third molars

Diet and snacking habits: exposure to carbohydrates, sugars and pop
Dental injury prevention
Sealants on bicuspid and 6- and 12-year molars
Mouth guards for sports
Smoking and smokeless tobacco
Drug use (methamphetamines)
Oral piercing

Development

Normal biopsychosocial changes of adolescence

Gender Specific Health

Abstinence education
Contraception, condom use
HIV counseling or referral
Self breast exam
Self testicular exam
Sexual abuse, date rape

Gender-specific sexual development
Sexual orientation
Sexual responsibility, decision making
Sexually transmitted diseases
Unintended pregnancy

Health Consumer Issues


Selection and purchase of health devices or items

Selection and use of health services

Injury Prevention

ATV safety
CPR and first aid training
Dangers of farm ponds and creeks
Falls
Firearm safety, hunting practices
Gun and hunter safety
Handling agricultural chemicals
Hearing conservation
Machinery safety
Motorized vehicle safety (ATV, moped, motorcycle, car, and trucks)

Overexposure to sun
ROPS (roll over protective structure)
Seat belt usage
Helmet usage
Smoke detector
Sports recreation, workshop laboratory, job, or home injury prevention
Tanning practices
Violent behavior
Water safety
High noise levels

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d. Oral Health Screening

The purpose of the oral health screening is to identify dental anomalies or diseases, such as dental caries (decay), soft tissue lesions, gum disease, or developmental problems and to ensure that preventive dental education is provided to the parents or guardians.

Unlike other health needs, dental problems are so prevalent that most children over 12 months will need diagnostic evaluation and treatment. An oral screening includes a medical and dental history and an oral evaluation. Each component of the oral screening listed below must be documented in the child's record.

◆ Medical and dental history:

- Current or recent medical conditions
- Current medications used
- Allergies
- Name of child's physician and dentist
- Date of last dental visit or frequency of dental visits
- Use of fluoride by child (source of water, use of fluoridated toothpaste or other fluoride products)
- Current or recent dental problems or injuries
- Home care (frequency of brushing, flossing, or other oral hygiene practices)
- Snacking and feeding habits

◆ Oral evaluation

- Presence of decay
- Presence of demineralized areas (white spots)
- Presence of visible plaque
- Presence of gingivitis or other soft tissue conditions
- Presence of enamel defects
- Presence of sealants
- Presence of restored teeth



- Physical examination. Abnormality of any of the following which indicates poor nutrition: hair, skin or nails, eyes, teeth or gums, disorders of the thyroid or parotid glands, gastrointestinal disorders, neurological disorders, or skeletal disorders.

Source: *Report of the Expert Panel on Blood Cholesterol Levels in Children and Adolescents*. U.S. Department of Health and Human Services, September 1991.

c. Vision

Examination of the eyes should begin in the newborn period and should be done at all well infant and well child visits. Comprehensive examination of children is recommended as a part of the regular plan for continuing care beginning at three years of age.

At each visit, obtain a history to elicit from parents evidence of any visual difficulties. During the newborn period, infants who may be at risk for eye problems include those who are premature (e.g., retinopathy of prematurity) and those with family history of congenital cataracts, retinoblastoma, and metabolic and genetic diseases.

(1) Birth To Age Three

Eye evaluations of infants and children birth to age three years should include:

- ◆ Ocular history.
- ◆ Vision assessment.
- ◆ External inspection of the eyes and lids.
- ◆ Ocular motility assessment.
- ◆ Pupil examination.
- ◆ Red reflex examination.

(2) At Three Years and Older

In addition to all the eye evaluations listed for infants and young children, two additional measures should be included. Beginning as early as age 2½ to 3 years, children should receive objective vision testing using picture cards. (See the following [chart](#) for suggested tests.)



Three-year-old-children who are uncooperative when tested should be retested four to six months later. Make a referral for an eye examination if the test cannot be completed on the second attempt. The referral should be to an optometrist or ophthalmologist who is experienced in treating children.

In addition to visual acuity testing, children four years old may cooperate by fixating on a toy while the ophthalmoscope is used to evaluate the optic nerve and posterior eye structures.

(3) At Five Years and Older

Children five years and older should receive all the previously described eye examinations and screening described for younger children.

During the preschool years, muscle imbalance testing is very important. The guidelines above suggest assessing muscle imbalance by use of the corneal light reflex test, unilateral cover test at near and far distance, and random-dot-E test for depth perception.

As the child reaches school age, refractive errors that may require eyeglasses for correction become important. The most common refractive error is hyperopia or far-sightedness. Hyperopia can cause problems in performing close work. Therefore, referral to an eye care specialist is recommended. Uncorrected hyperopia is very common in learning-related vision problems.

In addition, the following behaviors may be indicative of myopia:

- ◆ Tendency to squint.
- ◆ Holding toys or books close to the eyes.
- ◆ Difficulty recognizing faces at a distance.
- ◆ Failure to pass a school vision screening.
- ◆ Complaint that the classroom blackboard has become difficult to see.

Source: Hagan JF, Shaw JS, Duncan PM, eds. 2008, *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, Third Edition. Elk Grove Village, IL: American Academy of Pediatrics, page 231.



VISION SCREENING GUIDELINES

Function: Recommended Tests	Referral Criteria	Comments
Distance visual acuity: <ul style="list-style-type: none">◆ Snellen chart◆ Tumbling E◆ HOTV test◆ Picture tests:<ul style="list-style-type: none">• Allen cards• LH symbols	Ages 3-5 years: <ol style="list-style-type: none">1. <4 of 6 correct on 20 ft line with either eye tested at 10 ft monocularly (i.e., <10/20 or 20/40) or2. Two-line difference between eyes, even within the passing range (i.e., 10/12.5 and 10/20 or 20/25 and 20/40) Ages 6 years and older: <ol style="list-style-type: none">1. <4 of 6 correct on 15 ft line with either eye tested at 10 ft monocularly (i.e., <10/15 or 20/30)2. Two-line difference between eyes, even within the passing range (i.e., 10/10 and 10/15 or 20/20 and 20/30)	<ol style="list-style-type: none">1. Tests are listed in decreasing order of cognitive difficulty. Use the highest test that the child is capable of performing. In general, the tumbling E or the HOTV test should be used for ages 3-5 years and Snellen letters or numbers for ages 6 years and older.2. Testing distance of 10 ft is recommended for all visual acuity tests.3. A line of figures is preferred over single figures.4. The nontested eye should be covered by an occluder held by the examiner or by an adhesive occluder patch applied to eye. The examiner must ensure that it is not possible to peek with the nontested eye.



Function: Recommended Tests	Referral Criteria	Comments
Ocular alignment:		
♦ Corneal light reflex test		
♦ Simultaneous red reflex test (Bruckner)		
♦ Cross cover test at 10 ft or 3 m	Any eye movement	
♦ Random-dot-E stereo test at 40 cm (630 s of arc)	< 4 of 6 correct	

Source: American Academy of Pediatrics Committee on Practice and Ambulatory Medicine; Section on Ophthalmology, American Association of Certified Orthoptists; American Association for Pediatric Ophthalmology and Strabismus; and American Academy of Ophthalmology. Eye examination in infants, children, and young adults by pediatricians. *Pediatrics*, 2003; 111:902-907, (page 902)

d. Hearing

Each child up to age 3 should have an objective hearing screen or documented parent refusal. Objective screening of hearing for all neonates is now recommended by the Joint Committee on Infant Hearing. See www.jcih.org/posstatements.htm.

Objective hearing screening should be performed on all infants before age one month. Newborn infants who have **not** had an objective hearing test should be referred to an audiologist who specializes in infant screening using one of the latest audiology screening technologies.

Infants who do not pass the initial hearing screen and the subsequent rescreening should have appropriate audiology and medical evaluations to confirm the presence of hearing loss before 3 months.

All infants with confirmed hearing loss should receive intervention services before 6 months of age.



For information on audiologists in your area, see the early hearing detection and intervention system (EDHI) website, www.idph.state.ia.us/iaehdi/default.asp or call 1-800-383-3826.

An objective hearing screening should be performed on all infants and toddlers who do not have a documented objective newborn hearing screening or documented parental refusal. This screening should be conducted by a qualified screener during well-child health screening appointments according to the periodicity schedule.

Objective hearing screening performed on newborns and infants will detect congenital hearing loss, but will not identify those children with late onset hearing loss. In order to be alert to late onset hearing loss, health providers should also monitor developmental milestones, auditory and speech skills, middle ear status, and should consider parental concerns.

A child of any age who has not had objective hearing screening should be referred for audiology evaluation to rule out congenital hearing loss.

The following risk indicators are associated with either congenital or delayed-onset hearing loss. Heightened surveillance of all children with risk indicators is recommended. Risk indicators marked with an asterisk are greater concern for delayed-onset hearing loss.

- ◆ Caregiver concern* regarding hearing, speech, language, or developmental delay (Roizen, 1999)
- ◆ Family history* of permanent childhood hearing loss (Cone-Wesson et al., 2000; Morton & Nance, 2006).
- ◆ Neonatal intensive care of more than 5 days, or any of the following regardless of length of stay:
 - ECMO,*
 - Assisted ventilation,
 - Hyperbilirubinemia requiring exchange transfusion, and
 - Exposure to ototoxic medications (gentamycin and tobramycin) or loop diuretics (furosemide/lasix).(Fligor et al., 2005; Roizen, 2003).
- ◆ In-utero infections, such as CMV, *herpes, rubella, syphilis, and toxoplasmosis (Fligor et al., 2005; Fowler et al., 1992; Madden et al., 2005; Nance et al., 2006; Pass et al., 2006; Rivera et al., 2002).




- ◆ Craniofacial anomalies, including those involving the pinna, ear canal, ear tags, ear pits, and temporal bone anomalies (Cone-Wesson et al., 2000).
- ◆ Physical finding, such as white forelock, associated with a syndrome known to include a sensorineural or permanent conductive hearing loss (Cone-Wesson et al., 2000).
- ◆ Syndromes associated with hearing loss or progressive or late-onset hearing loss, * such as neurofibromatosis, osteopetrosis, and Usher syndrome (Roizen, 2003). Other frequently identified syndromes include Waardenburg, Alport, Pendred, and Jervell and Lange-Nielson (Nance, 2003).
- ◆ Neurodegenerative disorders, * such as Hunter syndrome, or sensory motor neuropathies, such as Friedreich ataxia and Charcot-Marie-Tooth syndrome (Roizen, 2003).
- ◆ Culture-positive postnatal infections associated with sensorineural hearing loss, * including confirmed bacterial and viral (especially herpes viruses and varicella) meningitis (Arditi et al., 1998; Bess, 1982; Biernath et al., 2006; Roizen, 2003).
- ◆ Head trauma, especially basal skull/temporal bone fracture* requiring hospitalization (Lew et al., 2004; Vartialnen et al., 1985; Zimmerman et al., 1993).
- ◆ Chemotherapy* (Bertolini et al., 2004).

See Appendix D, *Hearing Screening Bright Futures, Guidelines for Health Supervision of Infants, Children, and Adolescents*, Second Edition, for additional information. www.brightfutures.org

D. BASIS OF PAYMENT FOR SERVICES

Payment to a screening center for services is on a fee-for-service basis. Submit all the actual costs of the screening examination, lab tests, and immunizations.

Bill all procedures in whole units of service. For most codes, 15 minute equals one unit. Round remainders of seven minutes or less down to the lower unit and remainders of more than seven minutes up to the next unit.

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E. RECORDS

The documentation for each "patient encounter" shall include the following (when appropriate):


- ◆ Complaint and symptoms; history; examination findings; diagnostic test results; assessment, clinical impression or diagnosis; plan for care; date; and identity of the observer.
- ◆ Specific procedures or treatments performed.
- ◆ Medications or other supplies.
- ◆ Patient's progress, response to and changes in treatment, and revision of diagnosis.
- ◆ Information necessary to support each item of service reported on the Medicaid claim form.
 - Date of service.
 - Place of service.
 - Name of member.
 - Name of provider agency and person providing the service.
 - Nature, content, or units of service. Maintain a record of the time to support the units on the claim form. (Time must include AM/PM.)

Documentation of medical transportation services shall include the following:

- ◆ Date of service
- ◆ Member's name
- ◆ Address of where recipient was picked up
- ◆ Destination (medical provider's name and address)
- ◆ Invoice of cost
- ◆ Mileage if the transportation is paid per mile

Providers of service shall maintain fiscal records in support of each item of service for which a charge is made to the program. The fiscal record does not constitute a clinical record.

Failure to maintain supporting fiscal and clinical records may result in claim denials or recoupment of Medicaid payment.

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As a condition of accepting Medicaid payment for services, providers are required to provide the Iowa Medicaid program access to client medical records when requested. Providers shall make the medical and fiscal records available to the Department or its duly authorized representative on request.

F. PROCEDURE CODES AND NOMENCLATURE

Iowa uses the CMS Health Care Procedures Coding System (HCPCS). Bill the screening examination using the appropriate preventive office CPT code. Claims submitted without a CPT code, modifier code, and an ICD-9 diagnosis code will be denied.

New Patient

- 99381 **Initial preventive medicine** evaluation and management of an individual including a comprehensive history, a comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate laboratory/diagnostic procedures, new patient; infant (age under 1 year)
- 99382 Early childhood (age 1 through 4 years)
- 99383 Late childhood (age 5 through 11 years)
- 99384 Adolescent (age 12 through 17 years)
- 99385 18-20 years

Established Patient

- 99391 **Periodic preventive medicine** reevaluation and management of an individual including a comprehensive history, a comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate laboratory/diagnostic procedures, established patient; infant (age under 1 year)
- 99392 Early childhood (age 1 through 4 years)
- 99393 Late childhood (age 5 through 11 years)
- 99394 Adolescent (age 12 through 17 years)
- 99395 18-20 years

Use the following modifier if applicable:

<u>Modifier</u>	<u>Description</u>
U1	Indicate a referral for treatment

If a follow-up visit is scheduled after the preventive visit, use the following code and an appropriate ICD-9 code.

- 99211 Office or other outpatient visit for the evaluation and management of an established patient.



1. Home Visits

<u>Code</u>	<u>Description</u>
-------------	--------------------

S9123	Nursing visit in the home, per hour
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S9127	Social work visit in the home (encounter code)
-------	--

Use the appropriate ICD-9 diagnosis code.

2. Nutritional Counseling

Payment for nutritional counseling services will be made using the following codes:

<u>Code</u>	<u>Description</u>
-------------	--------------------

97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes.
-------	---

97803	Reassessment and intervention, individual, face-to-face with the patient, each 15 minutes
-------	---

In the diagnosis area of the claim form, use the diagnosis appropriate for the condition being treated.

3. Testing

Bill specific laboratory and testing services as follows:

<u>Code</u>	<u>Description</u>
-------------	--------------------

36416	Collection of capillary blood specimen (e.g. finger, heel, ear stick) (Can not be used in conjunction with 99000.)
-------	---

36415	Collection of venous blood by venipuncture (Can not be used in conjunction with 99000)
-------	--

96110	Developmental testing, limited, with interpretation and report
-------	--

99000	Handling or conveyance of specimen for transfer to a lab (Can not be used with 36415/36416)
-------	---

85014	Hematocrit
-------	------------

85018	Hemoglobin
-------	------------

83655	Lead
-------	------

92555	Speech audiometry (threshold only)
-------	------------------------------------

86580	Tuberculosis, intradermal
-------	---------------------------

81002	Urinalysis
-------	------------

99173	Visual acuity (will not be paid if used with the preventive visit code)
-------	---



4. Immunizations

Providers must provide immunizations under the Vaccines for Children Program (VFC). When a child receives a vaccine outside of the VFC schedule, Medicaid will provide reimbursement.

Immunizations are usually given in conjunction with a medical service. When an immunization is the only service performed, you may list a minimal service in addition to the injection. Immunization procedures include the supply of related materials.

You must provide Medicaid immunizations under the Vaccines for Children Program (VFC). Vaccines available through the VFC program are found at http://www.idph.state.ia.us/adper/vaccines_for_children.asp or at 1-800-831-6293.

For VFC vaccine, bill code 90471 and 90472 for vaccine administration in addition to the CPT code. The charges in box 24F should be "0" for the vaccine. Charge your usual and customary charge for the administration 90471 and 90472.

90473 (immunization administration by oral or nasal route) cannot be used with 90471.

5. Local Transportation

Only agencies designated by the Iowa Department of Public Health can bill for transportation services. In the diagnosis area of the claim form, use diagnosis code V68.9.

<u>Code</u>	<u>Description</u>	<u>Unit</u>
A0110	Non-emergency transportation and bus, intrastate or interstate carrier	Per round trip
A0100	Non-emergency transportation taxi--intracity	Per round trip
A0130	Non-emergency transportation; wheelchair van	Per round trip
A0090	Non-emergency transportation per mile-volunteer interested individual, neighbor	Per mile
A0120	Non-emergency transportation mini-bus, mountain area transports, other non-profit transportation systems	Per round trip
A0170	Transportation, parking fees, tolls, other	



6. Oral Health Services

In the diagnosis area of the claim form, use diagnosis code 528.9.

<u>Code</u>	<u>Procedure</u>	<u>Comment</u>
D0120	Screening evaluation	Once every six months
D0145	Oral evaluation for patient under age three and counseling with primary caregiver	
D0150	Initial screening evaluation	
D0270	Bitewing, single film	
D0272	Bitewing, two films	
D0274	Bitewing, four films	
D1110	Adult prophylaxis	
D1120	Child prophylaxis	
D1206	Topical fluoride varnish	
D1310	Nutritional counseling for the control and prevention of oral disease	15-minute unit
D1330	Oral hygiene instruction	15-minute unit
D1351	Sealant, per tooth	

NOTE: for dental coding, a "child" is aged 12 or younger. An "adult" is aged 13 or older.

G. CLAIM FORM

Bill for screening examinations on the *Health Insurance Claim Form*, CMS-1500. To view a sample of this form on line, click [here](#).

1. Instructions for Completing the CMS-1500 Claim Form

The table below follows the CMS-1500 claim form by field number and name, and gives a brief description of the information to be entered and whether providing information in that field is required, optional, or conditional of the individual member's situation.

For electronic media claim (EMC) submitters, refer also to your EMC specifications for claim completion instructions.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
1.	CHECK ONE	REQUIRED. Check the applicable program block.
1a.	INSURED'S ID NUMBER	REQUIRED. Enter the Medicaid member's Medicaid number, found on the <i>Medical Assistance Eligibility Card</i> . The Medicaid "member" is defined as a recipient of services who has Iowa Medicaid coverage. The Medicaid number consists of seven digits followed by a letter, e.g., 1234567A. Verify eligibility by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902.
2.	PATIENT'S NAME	REQUIRED. Enter the last name, first name, and middle initial of the Medicaid member.
3.	PATIENT'S BIRTHDATE	OPTIONAL. Enter the Medicaid member's birth month, day, year, and sex. Completing this field may expedite processing of your claim.
4.	INSURED'S NAME	OPTIONAL. For Medicaid purposes, the "insured" is always the same as the patient. For Iowa Medicaid purposes, the member receiving services is always the "insured." If the member is covered through other insurance, the policyholder is the "other insured."
5.	PATIENT'S ADDRESS	OPTIONAL. Enter the address and phone number of the patient, if available.
6.	PATIENT RELATIONSHIP TO INSURED	OPTIONAL. For Medicaid purposes, the "insured" is always the same as the patient.
7.	INSURED'S ADDRESS	OPTIONAL. For Medicaid purposes, the "insured" is always the same as the patient.
8.	PATIENT STATUS	REQUIRED, IF KNOWN. Check boxes corresponding to the patient's current marital and occupational status.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
9a-d.	OTHER INSURED'S NAME	SITUATIONAL. Required if the Medicaid member is covered under other additional insurance. Enter the name of the policyholder of that insurance, as well as the policy or group number, the employer or school name under which coverage is offered, and the name of the plan or program. If 11d is "yes," these boxes must be completed.
10.	IS PATIENT'S CONDITION RELATED TO	REQUIRED, IF KNOWN. Check the applicable box to indicate whether or not treatment billed on this claim is for a condition that is somehow work-related or accident-related. If the patient's condition is related to employment or an accident, and other insurance has denied payment, complete 11d, marking the "yes" and "no" boxes.
10d.	RESERVED FOR LOCAL USE	OPTIONAL. No entry required.
11a-c.	INSURED'S POLICY GROUP OR FECA NUMBER	OPTIONAL. For Medicaid purposes, the "insured" is always the same as the patient.
11d.	IS THERE ANOTHER HEALTH BENEFIT PLAN?	REQUIRED. If the Medicaid member has other insurance, check "yes" and enter the payment amount in field 29. If "yes," then boxes 9a-9d must be completed. If there is no other insurance, check "no." If you have received a denial of payment from another insurance, check both "yes" and "no" to indicate that there is other insurance, but that the benefits were denied. Proof of denials must be included in the patient record. Request this information from the member. You may also determine if other insurance exists by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902. NOTE: Auditing will be performed on a random basis to ensure correct billing.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
12.	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	OPTIONAL. No entry required.
13.	INSURED OR AUTHORIZED PERSON'S SIGNATURE	OPTIONAL. No entry required.
14.	DATE OF CURRENT ILLNESS, INJURY, PREGNANCY	SITUATIONAL. Enter the date of the onset of treatment as month, day, and year. For pregnancy, use the date of the last menstrual period (LMP) as the first date. This field is not required for preventative care.
15.	IF THE PATIENT HAS HAD SAME OR SIMILAR ILLNESS...	SITUATIONAL. Chiropractors must enter the current X-ray as month, day, and year. For all others, no entry is required.
16.	DATES PATIENT UNABLE TO WORK...	OPTIONAL. No entry required.
17.	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	CONDITIONAL. Required if the referring provider is not enrolled as an Iowa Medicaid provider. "Referring provider" is defined as the health care provider that directed the patient to your office.
17a.		LEAVE BLANK. The claim will be returned if any information is entered in this field.
17b.	NPI	SITUATIONAL. If the patient is a MediPASS member and the MediPASS provider authorized service, enter the 10-digit national provider identifier (NPI) of the referring provider. If this claim is for consultation, independent lab, or DME, enter the NPI of the referring or prescribing provider. If the patient is on lock-in and the lock-in provider authorized the service, enter that provider's NPI.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
18.	HOSPITALIZATION DATES RELATED TO...	OPTIONAL. No entry required.
19.	RESERVED FOR LOCAL USE	OPTIONAL. No entry required. Note that pregnancy is now indicated with a pregnancy diagnosis code in box 21. If you are unable to use a pregnancy diagnosis code in any of the fields in box 21, write in this box, "Y – Pregnant."
20.	OUTSIDE LAB	OPTIONAL. No entry required.
21.	DIAGNOSIS OR NATURE OF ILLNESS	REQUIRED. Indicate the applicable ICD-9-CM diagnosis codes in order of importance (1-primary, 2-secondary, 3-tertiary, and 4-quaternary), to a maximum of four diagnoses. Do not enter descriptions If the patient is pregnant, one of the diagnosis codes must indicate pregnancy. The pregnancy diagnosis codes are as follows: 640 through 648, 670 through 677, V22, V23
22.	MEDICAID RESUBMISSION CODE...	This field will be required at a future date. Instructions will be provided before the requirement is implemented.
23.	PRIOR AUTHORIZATION NUMBER	SITUATIONAL. If there is a prior authorization, enter the prior authorization number. Obtain this number from the prior authorization form.
24. A	DATE(S) OF SERVICE/NDC TOP SHADED PORTION	SITUATIONAL. Required for provider-administered drugs. Enter qualifier "N4" followed by the NDC for the drug referenced in 24d (HCPCs). No spaces or symbols should be used in reporting this information.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
	LOWER PORTION	REQUIRED Enter the month, day, and year under both the "From" and "To" categories for each procedure, service or supply. If the "From-To" dates span more than one calendar month, enter each month on a separate line. Because eligibility is approved on a month-by-month basis, spanning or overlapping billing months could cause the entire claim to be denied.
24. B	PLACE OF SERVICE	REQUIRED. Using the chart below, enter the number corresponding to the place service was provided. Do not use alphabetic characters. 11 Office 12 Home 21 Inpatient hospital 22 Outpatient hospital 23 Emergency room – hospital 24 Ambulatory surgical center 25 Birthing center 26 Military treatment facility 31 Skilled nursing 32 Nursing facility 33 Custodial care facility 34 Hospice 41 Ambulance – land 42 Ambulance – air or water 51 Inpatient psychiatric facility 52 Psychiatric facility – partial hospitalization 53 Community mental health center 54 Intermediate care facility/mentally retarded 55 Residential substance abuse treatment facility 56 Psychiatric residential treatment center 61 Comprehensive inpatient rehabilitation facility 62 Comprehensive outpatient rehabilitation facility 65 End-stage renal disease treatment 71 State or local public health clinic 72 Rural health clinic 81 Independent laboratory 99 Other unlisted facility



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
24. C	EMG	OPTIONAL. No entry required.
24. D	PROCEDURES, SERVICES OR SUPPLIES	REQUIRED. Enter the codes for each of the dates of service. Do not list services for which no fees were charged. Do not enter the description. Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code or valid Current Procedural Terminology (CPT) codes. When applicable, show the HCPCS code modifiers with the HCPCS code.
24. E	DIAGNOSIS POINTER	REQUIRED. Indicate the corresponding diagnosis code from field 21 by entering the number of its position, e.g., 3. Do not write the actual diagnosis code in this field. Doing so will cause the claim to deny. There is a maximum of four diagnosis codes per claim.
24. F	\$ CHARGES	REQUIRED. Enter the usual and customary charge for each line item. This is defined as the provider's customary charges to the public for the services.
24. G	DAYS OR UNITS	REQUIRED. Enter the number of times this procedure was performed or number of supply items dispensed. If the procedure code specifies the number of units, then enter "1." When billing general anesthesia, the units of service must reflect the total minutes of general anesthesia.
24. H	EPSDT/FAMILY PLANNING	SITUATIONAL. Enter "F" if the service on this claim line is for family planning. Enter "E" if the services on this claim line are the result of an EPSDT Care for Kids screening.
24. I	ID QUAL.	LEAVE BLANK. The claim will be returned if any information is entered in this field.
24. J	RENDERING PROVIDER ID # TOP SHADED PORTION LOWER PORTION	LEAVE BLANK REQUIRED. Enter the NPI of the provider rendering the service when the NPI given in field 33a does not identify the treating provider.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
25.	FEDERAL TAX ID NUMBER	OPTIONAL. No entry required.
26.	PATIENT'S ACCOUNT NUMBER	FOR PROVIDER USE. Enter the account number you have assigned to the patient. This field is limited to 10 alphabetical or numeric characters.
27.	ACCEPT ASSIGNMENT?	OPTIONAL. No entry required.
28.	TOTAL CLAIM CHARGE	REQUIRED. Enter the total of the line-item charges. If more than one claim form is used to bill services performed, each claim form must be separately totaled. Do not carry over any charges to another claim form.
29.	AMOUNT PAID	SITUATIONAL. Enter only the amount paid by other insurance. Do not list member copayments, Medicare payments, or previous Medicaid payments on this claim. Do not submit this claim until you receive a payment or denial from the other carrier. Proof of denial must be kept in the patient record.
30.	BALANCE DUE	REQUIRED. Enter the amount of total charges less the amount entered in field 29.
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER	REQUIRED. Enter the signature of either the provider or the provider's authorized representative and the original filing date. The signatory must be someone who can legally attest to the service provided and can bind the organization to the declarations on the back of the claim form. If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used.
32.	SERVICE FACILITY LOCATION INFORMATION	OPTIONAL. Enter the name and address associated with the rendering provider.
32a.	NPI	OPTIONAL. Enter the NPI of the facility where services were rendered.
32b.		LEAVE BLANK. The claim will be returned if any information is entered in this field.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
33.	BILLING PROVIDER INFO AND PHONE #	REQUIRED. Enter the complete name and address of the billing provider. The "billing provider" is defined as the provider that is requesting to be paid for the services rendered. The address must contain the ZIP code associated with the billing provider's NPI. NOTE: The ZIP code must match the ZIP code confirmed during NPI verification. To view the confirmed ZIP code, access imeservices.org .
33a.	NPI	REQUIRED. Enter the ten-digit NPI of the billing provider.
33b.		REQUIRED. Enter qualifier "ZZ" followed by the taxonomy code of the billing provider. No spaces or symbols should be used. The taxonomy code must match the taxonomy code confirmed during NPI verification. To view the confirmed taxonomy code, access imeservices.org .


2. Claim Attachment Control, Form 470-3969

If you want to submit electronically a claim that requires an attachment, you must submit the attachment on paper using the following procedure:

- ◆ **Staple** the additional information to form 470-3969, *Claim Attachment Control*. (To view a sample of this form on line, click [here](#).)
- ◆ Complete the "attachment control number" with the same number submitted on the electronic claim. IME will accept up to 20 characters (letters or digits) in this number. If you do not know the attachment control number for the claim, please contact the person in your facility responsible for electronic claims billing.
- ◆ **Do not** attach a paper claim.
- ◆ Mail the *Claim Attachment Control* with attachments to:

Iowa Medicaid Enterprise
PO Box 150001
Des Moines, IA 50315

Once IME receives the paper attachment, it will manually be matched up to the electronic claim using the attachment control number and then processed.

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H. REMITTANCE ADVICE

1. Remittance Advice Explanation

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting.

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied, and suspended claims.

- ◆ **Paid** indicates all processed claims, credits and adjustments for which there is full or partial reimbursement.
- ◆ **Denied** represents all processed claims for which no reimbursement is made.
- ◆ **Suspended** reflects claims which are currently in process pending resolution of one or more issues (member eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print depending on which option was specified on the Medicaid Provider Application at the time of enrollment. You chose one of the following:

- ◆ Print suspended claims only once.
- ◆ Print all suspended claims until paid or denied.
- ◆ Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a "1" in the twelfth position and reimbursement appears as a negative amount.

An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a "2" in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit – the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.



An example of the *Remittance Advice* and a detailed field-by-field description of each informational line follow. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

Regardless of one's understanding of the *Remittance Advice*, it is sometimes necessary to contact the IME Provider Services Unit with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

2. Remittance Advice Sample and Field Descriptions

To view a sample of this form on line, click [here](#).

NO.	FIELD NAME	DESCRIPTION
1.	To:	Billing provider's name as specified on the Medicaid Provider Enrollment Application.
2.	R.A. No.:	Remittance Advice number.
3.	Warr No.:	The sequence number on the check issued to pay this claim.
4.	Date Paid:	Date claim paid.
5.	Prov. Number:	Billing provider's Medicaid (Title XIX) number.
6.	Page:	<i>Remittance Advice</i> page number.
7.	Claim Type:	Type of claim used to bill Medicaid.
8.	Claim Status:	Status of following claims: <ul style="list-style-type: none">• Paid. Claims for which reimbursement is being made.• Denied. Claims for which no reimbursement is being made.• Suspended. Claims in process. These claims have not yet been paid or denied.



NO.	FIELD NAME	DESCRIPTION
9.	Patient Name	Member's last and first name.
10.	Recip ID	Member's Medicaid (Title XIX) number.
11.	Trans-Control-Number	Transaction control number assigned to each claim by the IME. Please use this number when making claim inquiries.
12.	Billed Amt.	Total charges submitted by provider.
13.	Other Sources	Total amount applied to this claim from other resources, i.e., other insurance or spenddown.
14.	Paid by Mcaid	Total amount of Medicaid reimbursement as allowed for this claim.
15.	Copay Amt.	Total amount of member copayment deducted from this claim.
16.	Med Recd Num	Medical record number as assigned by provider; 10 characters are printable.
17.	EOB	Explanation of benefits code for informational purposes or to explain why a claim denied. Refer to the end of the <i>Remittance Advice</i> for explanation of the EOB code.
18.	Line	Line item number.
19.	SVC-Date	The first date of service for the billed procedure.
20.	Proc/Mods	The procedure code for the rendered service.
21.	Units	The number of units of rendered service.
22.	Billed Amt.	Charge submitted by provider for line item.
23.	Other Sources	Amount applied to this line item from other resources, i.e., other insurance, spenddown.
24.	Paid by Mcaid	Amount of Medicaid reimbursement as allowed for this line item.



NO.	FIELD NAME	DESCRIPTION
25.	Copay Amt.	Amount of member copayment deducted for this line item.
26.	Perf. Prov.	Treating provider's Medicaid (Title XIX) number.
27.	S	Allowed charge source code: B Billed charge F Fee schedule M Manually priced N Provider charge rate P Group therapy Q EPSDT total screen over 17 years R EPSDT total under 18 years S EPSDT partial over 17 years T EPSDT partial under 18 years U Gynecology fee V Obstetrics fee W Child fee
28.	Remittance totals	(Found at the end of the <i>Remittance Advice</i>): <ul style="list-style-type: none">• Number of paid original claims, the amount billed by the provider, and the amount allowed and reimbursed by Medicaid.• Number of paid adjusted claims, amount billed by the provider, and the amount allowed and reimbursed by Medicaid.• Number of denied original claims and the amount billed by the provider.• Number of denied adjusted claims and the amount billed by the provider.• Number of pended claims (in process) and the amount billed by the provider.• Amount of the check (warrant) written to pay these claims.
29.	Description of EOB code	Lists the individual explanation of benefits codes used, followed by the meaning of the code and advice.